## DISSENTING VIEWS TO H.R. 5

### Introduction

H.R. 5[1] is among the most dangerous, one-sided liability limitation bills ever considered by the Congress--far worse than any measure considered during the Contract with America.

The most obvious problem with H.R. 5 is that it does not solve the problem it purports to address. Study after study have shown that draconian laws capping damages do not reduce insurance premiums. Comparisons of states that have enacted severe tort restrictions and those that have not found no correlation between liability limitation laws and insurance rates.[2] Indeed, some of the resisting states experienced lower increases in insurance rates, while some states that enacted liability limitation laws experienced higher rate increases relative to the national trends. For example, data from the 2002 Medical Liability Monitor shows that Michigan, a state with caps, had one of the highest average premiums in the country, while Minnesota and Oklahoma, two states without caps, had two of the three lowest average rates in the country.[3] Data from the 2001 Medical Liability Monitor showed that in the practice of internal medicine, states with caps on damages had higher premiums than states without caps.[4] For general surgeons, insurance premiums were 2.3% higher in states with caps on damages.[5] On average, malpractice premiums were no higher in the 27 States that have no limitations on malpractice damages, than in the 23 States that do have such limits.[6]

So why are medical malpractice premiums rising? The principal culprit is the insurance industry. Insurers make their money from investment income, which is plummeting right now. During years of high stock market returns and interest rates, malpractice premiums go down. When investment income decreases – and we are in the middle of a four year bear market – the industry responds by sharply increasing premiums and reducing coverage, creating a "liability insurance crisis." This boom-bust cycle took place in the 70's and 80's, and its happening again

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[1] Help Efficient, Accessible, Low Cost, Timely Health Care (HEALTH) Act of 2003, H.R. 5, 108th Cong. (2003).

[2] Robert J. Hunter and Joanne Doroshow, *Premium Deceit–the Failure of "Tort Reform" to Cut Insurance Prices*, Center for Justice & Democracy (1999).

[3] *Medical Liability Monitor* (Oct. 2002).

[4] *Medical Liability Monitor* (Vol. 26, #10–Oct. 2001).

[5] *Id*.

[6] Senate Congressional Record, July 30, 2002, S7534.

now.[7]

There can be little doubt that H.R. 5 will work an obvious and irreparable unfairness on the hundreds of thousands of medical malpractice victims in this country. These victims include people like Linda McDougal, who received a double mastectomy when she didn't even have cancer, and Sherry Keller, who is now quadriplegic because her doctor failed to properly stitch the incision from her hysterectomy and then left her on an examination table for 35-45 minutes, during which time she went into shock, fell off the table, and banged her head. At a victims' forum held on February 11, 2003, Democrats invited these individuals as well as scores of other victims of medical malpractice to tell their story and to discuss how H.R. 5 negatively impacts them. Each informed us how an arbitrary $250,000 cap on their pain and suffering would work a blatant unfairness in their situation.

Beyond our concerns about the bill's unfair and unneeded limitations on medical malpractice, we have been given no justification for why the bill limits the liability of insurance companies and health maintenance organizatons (HMO's) for failure to provide coverage or for insulating drug and medical product manufacturers from liability.[8]

The bill takes no account of the fact that 5% of all health care professionals are responsible for 54% of all malpractice claims paid.[9] The bill also ignores the fact that between 44,000 and 98,000 people die each and every year from medical malpractice.[10] The last thing we need to do is exacerbate the problem, while ignoring the true causes of the medical malpractice crisis in America. Yet this is precisely what H.R. 5 does.

The following is a brief description of the bill and a more detailed itemization of our concerns with it.

**Description of Legislation**

H.R. 5 limits the amount of non-economic damages–damages for pain and suffering–to $250,000.[11]

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[7] *See infra* Section II.B.

[8] *See infra* Section III.

[9] National Practitioner Data Bank, Sept. 1, 1990 - Sept. 30, 2002.

[10] Kohn, Corrigan, Donaldson, eds., *To Err is Human: Building a Safer Health System*, Institute of Medicine, National Academy Press: Washington, DC (1999).

[11] H.R. 5, § 4(b). "In any health care lawsuit, the amount of noneconomic damages recovered may be as much as $250,000, regardless of the number of parties against whom the

In addition, H.R.5 eliminates joint and several liability, a longstanding common law doctrine that ensures that victims will be made whole.[12] Similarly, the bill alters the rules of evidence regarding a collateral source and eliminates the doctrine of subrogation, the effect of which is to shift the costs of malpractice from negligent defendants to innocent victims.[13]

The bill dramatically limits a victim's ability to recover punitive damages in two distinct ways. First, the bill imposes a heightened standard for the recovery of punitive damages, requiring clear and convincing evidence that the defendant acted with malicious intent to injure the victim, or the defendant understood the victim was substantially certain to suffer unnecessary

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action is brought or the number of separate claims or actions brought with respect to the same occurrence." *Id.* This provision does not apply if a state law "specifies a particular monetary amount of compensatory or punitive damages . . . that may be awarded in a health care lawsuit, regardless of whether such monetary amount is greater or lesser than is provider for under this Act." *Id*. at §11(c).

[12] Relief from joint and several liability is addressed under the Fair Share Rule:

> FAIR SHARE RULE- In any health care lawsuit, each party shall be liable for that party's several share of any damages only and not for the share of any other person. Each party shall be liable only for the amount of damages allocated to such party in direct proportion to such party's percentage of responsibility. A separate judgment shall be rendered against each such party for the amount allocated to such party. For purposes of this section, the trier of fact shall determine the proportion of responsibility of each party for the claimant's harm.

H.R. 5, § 4(d).

[13] The topic is addressed under the topic of Additional Health Benefits:

> In any health care lawsuit, any party may introduce evidence of collateral source benefits. If a party elects to introduce such evidence, any opposing party may introduce evidence of any amount paid or contributed or reasonably likely to be paid or contributed in the future by or on behalf of the opposing party to secure the right to such collateral source benefits. No provider of collateral source benefits shall recover any amount against the claimant or receive any lien or credit against the claimant's recovery or be equitably or legally subrogated to the right of the claimant in a health care lawsuit. This section shall apply to any health care lawsuit that is settled as well as a health care lawsuit that is resolved by a fact finder. This section shall not apply to section 1862(b) (42 U.S.C. 1395y(b)) or section 1902(a)(25) (42 U.S.C. 1396a(a)(25)) of the Social Security Act.

H.R. 5, § 6.

injury yet deliberately failed to avoid such injury.[14] It also limits punitive damages to two times the amount of economic damages or $250,000, whichever is greater.[15]

The second category of punitive damages affected by the bill relates to manufacturers and distributors of drugs and medical devices. Specifically, the bill bans punitive damage liability for manufacturers of drugs and devices that are approved by the FDA.[16] It also extends this immunity to the manufacturers of drugs and devices that are not FDA-approved but are "generally recognized among qualified experts as safe and effective," and to manufacturers or sellers of drugs from punitive damages for packaging or labeling defects.[17] The only exceptions to this section, allowing a defendant to be held liable, are if the defendant knowingly misrepresented to or withheld from the FDA information that is required to be submitted, and that information caused the harm, or if the defendant made an illegal payment to an official of the FDA to secure market approval.[18]

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[14] H.R. 5, § 7(a).

[15] H.R. 5, § 7(b)(2).

[16] H.R. 5, § 7(c).

(1) No punitive damages may be awarded against the manufacturer or distributor of a medical product based on a claim that such product caused the claimant's harm where--

> (A)(i) such medical product was subject to premarket approval or clearance by the Food and Drug Administration with respect to the safety of the formulation or performance of the aspect of such medical product which caused the claimant's harm or the adequacy of the packaging or labeling of such medical product; and
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> (ii) such medical product was so approved or cleared;

H.R. 5, § 7(c)(1)(A).

[17] If manufacturers and distributors do not fall under Section 7(c)(1)(A), they are still exempt from punitive damages if:

> (B) such medical product is generally recognized among qualified experts as safe and effective pursuant to conditions established by the Food and Drug Administration and applicable Food and Drug Administration regulations, including without limitation those related to packaging and labeling, unless the Food and Drug Administration has determined that such medical product was not manufactured or distributed in substantial compliance with applicable Food and Drug Administration statutes and regulations.

H.R. 5, § 7(c)(1)(B).

[18] Section 7(c)(4) provides that a health care provider may be liable if the person "before or after premarket approval or clearance of such medical product, knowingly misrepresented to or withheld from the [FDA] information that is required to be submitted under

H.R. 5 also sets unprecedented limits on the amount an attorney may receive in contingency fee payments. Specifically, the total amount of all contingent fees for representing all claimants in a health care lawsuit may not exceed: (1) 40% of the first $50,000 recovered by the claimant(s); (2) 33 1/3% of the next $50,000 recovered by the claimant(s); (3) 25% of the next $500,000 recovered by the claimant(s); and (4) 15% of any amount by which the recovery by the claimant(s) is in excess of $600,000.[19]

H.R. 5 also provides an extremely restrictive statute of limitations for medical malpractice actions. It states that a "health care lawsuit may be commenced no later than 3 years after the date of manifestation of injury or 1 year after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury, *whichever occurs first*."[20] (emphasis added). Although disguised as a three year statute of limitation, the effect of this provision is that the claimant has exactly one year from the date of discovering the injury to file suit. This is because the claimant will *discover* the injury on the same day the injury *manifests* itself.[21]

The bill also provides for periodic payments rather than a lump sum payment to victims.[22] And finally, H.R. 5 is not limited to medical malpractice actions but covers lawsuits for failure to cover against HMOs and other health insurers as well.[23]

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the Federal Food, Drug, and Cosmetic Act . . . or section 351 of the Public Health Service Act . . . that is material and is casually related to the harm which the claimant allegedly suffered"; or "a person made an illegal payment to an official of the [FDA] for the purpose of either securing or maintaining approval or clearance of such medical product."

[19] H.R. 5, § 5(a).

[20] H.R. 5, § 3.

[21] The provision has two exceptions. The statute of limitations is tolled upon proof of fraud, intentional concealment, or the presence of a foreign body in the person injured. The second exception is for minors who have sustained injury before the age of 6. These victims may bring a lawsuit until the later of 3 years from the date of manifestation of the injury, or the date on which the minor attains the age 8. H.R. 5, §3.

[22] H.R. 5, § 8(a). "In any health care lawsuit, if an award of future damages, without reduction to present value, equaling or exceeding $50,000 is made against a party with sufficient insurance or other assets to fund a periodic payment of such a judgment, the court shall, at the request of any party, enter a judgment ordering that the future damages be paid by periodic payments in accordance with the Uniform Periodic Payment of Judgments Act promulgated by the National Conference of Commissioners on Uniform State Laws." *Id.*

[23] H.R. 5, § 9(7) defines a "health care lawsuit" as:
[A]ny health care liability claim concerning the provision of health care goods or

## I. Background

Medical malpractice is a tort-based legal claim for damages arising out of an injury caused by a health care provider. Tort claims are part of the "common law," or judge-made law, of the United States' civil justice system. Typically, tort claims have been reserved to the States.[24]

The tort system provides a number of benefits to society. First, it compensates victims who have been injured by the negligent conduct of others. Second, it deters future misconduct and carelessness that may cause injury and punishes wrongdoers who inflict injury. Third, it prevents future injury by removing dangerous products and practices from the marketplace. Fourth, it informs an otherwise unknowing public of such harmful products or practices, thereby expanding public health and safety.[25]

Most medical malpractice claims are based on the tort of "negligence," defined as conduct "which falls below the standard established by law for the protection of others against unreasonable risk of harm."[26] In medical malpractice cases, this legal standard is based on the practices of the medical profession,[27] and is usually determined based on the testimony of expert witnesses.

As with other torts, remedies for medical malpractice may consist of compensatory damage awards for economic losses such as medical expenses or lost wages; non-economic losses such as pain and suffering, reduced life expectancy, diminished quality of life, loss of a limb, loss

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> services, or any medical product, affecting interstate commerce, or any health care liability action concerning the provision of health care goods or services, or any medical product, affecting interstate commerce, brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider, a health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, regardless of the theory of liability on which the claim is based, or the number of claimants, plaintiffs, defendants, or other parties, or the number of claims or causes of action, in which the claimant alleges a health care liability claim.

[24] "Tort law at present is almost exclusively state law rather than federal law. . . ." *Federal Tort Reform Legislation: Constitutionality and Summaries of Selected Statutes* (CRS Report 95-797 A), at 1.

[25] Joan Claybrook, *Consumers and Tort Law*, 34 Fed. B. News & J. 127 (1987).

[26] Restatement (Second) of Torts § 282 (1965).

[27] David M. Harney, Medical Malpractice § 21.2, at 413 (2d ed 1987).

of fertility, loss of a child or spouse, and loss of mobility; and punitive damages to punish and deter willful and wanton conduct.

## II. General Concerns

A review of the empirical evidence gathered over the last decade supports a number of conclusions: first, medical malpractice is a serious problem in the United States; second, H.R. 5 does not respond to the problem of rampant medical malpractice and ignores the principal reason for the "crisis" it purports to solve - the insurance industry's cycles and practices; and third, liability limitation laws have not reduced premiums for medical malpractice to any significant extent.

### A. Medical malpractice is a serious problem in the United States.

Medical malpractice in the United States is a very real problem with devastating consequences. According to a study conducted in 1999 by the National Academy of Sciences Institute of Medicine ("IOM"), between 44,000 and 98,000 deaths occur each year in U.S. hospitals due to medical errors, and this does not even include malpractice committed at outpatient centers, physician offices and clinics.[28] These numbers are greater than the number of people who die due to motor vehicle accidents (43,458), breast cancer (42,297) or AIDS (16,516).[29]

Study after study have shown that the prevalence of medical malpractice extolls an enormous burden on its victims. A 1990 Harvard Medical Practice study found that medical negligence in New York hospitals results in 27,000 injuries and 7,000 deaths each year.[30] At a 1992 meeting of the American Association for the Advancement of Science, it was reported that more than 1.3 million hospitalized Americans, or nearly 1 in 25, are injured annually by medical treatment, and about 100,000 such patients, or 1 in 400, die each year as a direct result of such injuries.[31] A new study in *Pediatrics* magazine found that medical errors occurred in more than

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[28] *See* Kohn *et al.*, *supra* note 10. Using the lower estimate, medical malpractice in hospitals is the 8th leading cause of death in this country; using the higher estimate, it is the 5th leading cause of death. *Id*.

[29] *Id*.

[30] Harvard Medical Practice Study, Patients, Doctors and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York (1990).

[31] Christine Russell, *Human Error: Avoidable Mistakes Kill 100,000 Patients a Year*, Wash. Post Health Mag., Feb. 18, 1992; *see also* Harvey Wachsman, Lethal Medicine, The Epidemic of Medical Malpractice in America (1993).

one in 10 cases involving children with complex medical problems.[32]

Another recent study from Harvard Medical School and the University of Ottawa examined medical errors affecting patients after they were discharged from an unnamed teaching hospital.[33] The study, reported in the February 4, 2003 issue of the Annals of Internal Medicine, found that nearly 20% of 400 patients discharged from the hospital suffered an "adverse event" that occurred after discharge but resulted from the care they received at the hospital, rather than from an underlying disease or condition.[34] Thirty percent of those patients were temporarily disabled, and two of them suffered permanent disability–one from a life-threatening infection that followed a procedure and was not recognized while the patient was at the hospital.[35]

Almost every day now we read a new story about a botched surgery, a mix-up in the medical records, an unnecessary amputation, or the discovery of medical objects inside patients.[36] However, despite the high amount of malpractice being committed, the number of lawsuits filed on behalf of malpractice's victims is quite low. The landmark Harvard Medical Practice Study found that eight times as many patients are injured by malpractice as ever file a claim; 16 times as many suffer injuries as receive any compensation.[37] In contrast, the 1999 IOM study found that total national cost of medical malpractice (lost income, lost household production, disability and health care costs) is quite high, estimated to be between $17 billion and $29 billion each year.[38]

There is no denying that medical malpractice is a serious problem in our country right now. H.R. 5, however, does nothing about this problem. According to data from the National Practitioner Data Bank, from 1990 to 2002, just 5% of doctors were involved in 54% of all

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[32] Peter Eisler *et al*., *Hype Outraces Facts in Malpractice Debate*, USA Today, Mar. 5, 2003.

[33] *See* Sandra G. Boodman, *Medical Errors Come Home*, Wash. Post., Feb. 18, 2003 at HE01.

[34] *Id*.

[35] *Id*.

[36] *See, e.g.*, Shankar Vedantam, *Surgical Expertise, Undone by Error*, Wash. Post., Feb. 24, 2003, at A01; Rob Stein, *Teenage Girl in Botched Organ Transplant Dies*, Wash. Post., Feb. 23, 2003, at A01; *Mastectomy Mistake Fuels Debate*, CBSnews.com, Jan. 21, 2003; Denise Grady, *Forgotten Surgical Tools 'Uncommon but Dangerous,"* N.Y. Times, Jan. 21, 2003, at F5. (citing study that sponges or surgical instruments are left inside patients at least 1,500 times a year).

[37] *See supra* note 30.

[38] *See* Kohn *et al.*, *supra* note 10.

medical malpractice payouts, including jury awards and settlements.[39] The data shows that of the 35,000 doctors with two or more payouts during that period, only 8% were disciplined by state medical boards. Among the 2,774 doctors who had made payments in five or more cases, only 463 (1 in 6) had been disciplined.[40] An amendment offered by Mr. Berman during the markup of H.R. 5 would have provided for greater accountability of doctors. The amendment would have required states to make public the identity and mandate a reporting of the judgment or settlement of any case of malpractice over $10,000. It also would have made public any actions by a hospital to deny or suspend hospital privileges for bad doctors. Unfortunately, the amendment was defeated by a vote of 16-10.[41] H.R. 5 simply is not concerned with fixing the root problem of medical malpractice.

Along these same lines, a comparison of a recent report by the American Health Quality Association, which ranked states according to the quality of care delivered to Medicare beneficiaries, and the states that the AMA and PIAA say are in "crisis" shows that there is a significant relationship between those states in crisis and those states with the lowest quality of care rankings.[42] Specifically, a comparison shows that five of the twelve states (42%) currently in a medical liability "crisis" (according to the AMA/PIAA) ranked at the bottom 25% of all states for quality of care. Nine of the twelve states (75%) currently in a "crisis" rated in the bottom 50% of all states for quality of care.

Similarly, those states in "crisis" show a significant relationship to those states with poor doctor discipline records. For example, Pennsylvania–where doctors recently went on strike over insurance costs–has disciplined only 5% of the 512 doctors who had made payments in malpractice suits five or more times.[43] Moreover, Pennsylvania's 5.3% of the doctors in the United States makes up 18.5% of doctors nationally with five or more malpractice payments.[44] West Virginia, another state in crisis, has .57% of the country's physicians, but they make up 1.69% of doctors nationally who have made malpractice payments five or more times. Only one-fourth of those doctors have been disciplined by the medical review board.[45]

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[39] *See supra* note 9; *see also* Sidney M. Wolfe, *A Free Ride for Bad Doctors*, N.Y. Times, Mar. 4, 2003.

[40] *Id*.

[41] *See* Markup of H.R. 5, Transcript at pp. 62-82.

[42] *See* The American Health Quality Association, Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998-1999 to 2000-2001 (JAMA, 2003; 289: 305-312).

[43] *See* Sidney M. Wolfe, *A Free Ride for Bad Doctors*, N.Y. Times, Mar. 4, 2003.

[44] *Id*.

[45] *Id*.

### B. H.R. 5 ignores the principal cause of the "crisis"–the cyclical nature of the insurance industry and the investment practices of insurance companies.

Supporters of H.R. 5 claim that insurance companies have become insolvent or have left certain markets because of excessive litigation and unrestrained jury awards. This so-called "crisis" mirrors the last insurance "crisis" that hit the United States in the mid-1980s and an earlier one in the mid-1970s. Similar to its predecessors, today's insurance "crisis" has less to do with the legal system, tort laws, lawyers or juries and more to do with the insurance underwriting cycle and insurance companies' own investment practices.

Insurance industry experts have articulated the cyclical nature of the industry, showing a boom and bust cycle of so-called "crises" beginning in the 1970s.[46] During the first "crisis," medical malpractice insurance premiums increased by large margins and certain specialities were denied coverage.[47] As a result, all states but one initiated reforms designed to provide alternative sources of insurance and to reduce the number and costs of claims. Physician and hospital-owned insurance companies emerged as an alternative to traditional policy providers,[48] and, for at least a decade, insurance was accessible and affordable in a market dominated by these companies.

The mid-1980s saw another such "crisis." Prior to that, the insurance industry maintained affordable premiums and only minimal increases because of investments at high interest rates that produced significant yields. When interest rates dropped in 1984, however, insurance providers responded with considerable increases in medical malpractice insurance premiums.[49] The mid-1980s saw insurance rate increases of 300% or more for manufacturers, municipalities, doctors, nurse-midwives, day-care centers, non-profit groups and many other commercial customers of liability insurance.

As Joanne Doroshow, Executive Director of the Center for Justice and Democracy, testified at a hearing before the Subcommittee on Commercial and Administrative Law, what precipitates these crises is always the same:

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[46] U.S. Congress, Office of Technology Assessment, Pub. No. OTA-BP-H-119, Impact of Legal Reforms on Medical Malpractice Costs 13 (1993) [hereinafter OTA Report on Legal Reforms].

[47] *Id*.

[48] Medical insurance providers consist of both stock and mutual insurance companies. The physician and hospital owned companies are among the mutual insurance companies created to provide the lowest possible premiums.

[49] *See* OTA Report on Legal Reforms at 15.

> Insurers make their money from investment income. During years of high interest rates and/or insurer profits, insurance companies engage in fierce competition for premiums dollars to invest for maximum return. More specifically, insurers engage in severe underpricing to insure very poor risks just to get premium dollars to invest. But when investment income decreases because interest rates drop, the stock market plummets and/or cumulative price cuts make profits become unbearably low, the industry responds by sharply increasing premiums and reducing coverage, creating a "liability insurance crisis."[50]

Raul King, an economist and insurance industry expert at Congressional Research Service described today's situation at the victims' forum held by House Democrats on February 11, 2003:

> What has happened in the 1990s, after the last medical malpractice crisis in the mid-'80s is that in the 1990s the markets were up. For an extended period of time interest rates were relatively low, but the bottom line is that investments were very, very high, and they can continue to price their business in such a way to maximize premium for investment purposes.
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> Some would argue that starting in 2000 when not only the medical malpractice area but insurance in general, not just medical malpractice, but all P&C, property and casualty insurance, when the market cycle started to turn, investments were not what they expected. Interest rates were low, and across the board rates started firming up.
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> Incidentally, when the market is considered soft, coverage is readily available. Prices are relatively low. The insurance company will make their products available in the marketplace, and they will aggressively sell as much as they can because they want the business, and it's intensely competitive.
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> Some would argue that this soft market that went beyond the six years but right up close to ten years, and this what the consumer groups have argued as cash flow underwriting what Bob Hunter, for example, would argue is cash flow underwriting, they run into a problem. Their investments can't cover their premium losses and underwriting losses.

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[50] *See* Help Efficient, Accessible, Low Cost, Timely Health Care (HEALTH) Act of 2002: Hearing on H.R. 4600 before the House Subcomm. on Commercial and Admin. Law, 107th Cong. (June 1, 2002) (statement of Joanne Doroshow, Executive Director of the Center for Justice & Democracy) [hereinafter "Doroshow statement].

Another factor that affects insurance rates is the fact that since 1945 insurance companies have been exempt from antitrust laws. *See* McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015 (1945). Under the McCarran-Ferguson Act, courts have held that state regulation need not be meaningful or active in a particular instance to trigger the antitrust exemption. The result over the years has been uneven oversight of the insurance industry by the states, coupled with no possibility of federal antitrust enforcement, creating an environment that has fostered a wide range of anticompetitive practices.

> So what they have to do is to increase premiums dramatically. They have to in some cases withdraw from the marketplace, change the amount of insurance they'll make available in the marketplace. Rather than selling a $500,000 policy, they'll sell only a $250,000 policy, and that's all that's available in a given state.[51]

Thus, there are many factors, completely unrelated to jury verdicts and the civil justice system, that affect insurance rates, including: (1) changes in state law and regulatory requirements; (2) competitiveness within the insurance market; (3) the types of policies issued within the industry; (4) interest rates; (5) state socio-economic factors, such as urbanization; (6) national economic trends; and (7) huge portfolio losses due to the falling stock market.[52] According to the National Association of Insurance Commissioners, these factors fall into three categories: (a) changes in interest rates, (b) underpricing in soft markets, and (c) adverse shock-

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[51] *See* Democratic Forum on Malpractice, February 11, 2003, Transcript at 32-33. Another insurer described the problem as well:

> What is happening to the market for medical malpractice insurance in 2001 is a direct result of trends and events present since the mid to late 1990s. Throughout the 1990s and reaching a peak around 1997 and 1998, *insurers were on a quest for market share, that is, they were driven more by the amount of premium they could book rather than the adequacy of premiums to pay losses.* (Emphasis added). In large part this emphasis on market share was driven by a desire to accumulate large amounts of capital with which to turn into investment income. Driven in large part by lobbyist for the insurance industry and doctors' groups, H.R. 4600 is the latest attempt to "fix" the system. Unfortunately, H.R. 4600 does not address the real problems, which include the quantity of malpractice being committed by the medical profession and the inability of many victims to obtain reasonable compensation.
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> In a perfect world, investment income would cover any deficiencies that might exist in underwriting results and the insurers' aggressive marketing and pricing strategy would prove to be successful. Alas, we do not live in a perfect insurance world and, as competition intensified, underwriting results deteriorated. Regardless of the level of risk management intervention, proactive claims management, or tort reform, the fact remains that if insurance policies are consistently underpriced, the insurer will lose money.

*See* Charles Klodkin, *Medical Malpractice Insurance Trends? Chaos!,* Gallagher Healthcare Insurance Services (Sept. 2001).

[52] Numerous GAO studies and testimony over the past two decades have repeatedly demonstrated that the nexus between litigation, insurance rates, and health care costs is neither linear nor coextensive. *See, e.g., Medical Malpractice: A Continuing Problem With Far-Reaching Implications* (GAO/T-HRD-90-24), 101st Cong. (Apr. 26, 1990) (Statement of Charles A. Bowsher, Comptroller General of the United States).

losses that lead to super-competitive cycles.[53]

All three factors are present in the current crisis. Well before September 11th, the Federal Reserve cut interest rates several times, while insurers engaged in underpricing of the soft market.[54] The attacks of September 11th accelerated the price increases that had already begun by providing the adverse shock-loss component of the equation.[55] For example, St. Paul Insurance Company withdrew from the medical malpractice market, creating major supply and demand problems.[56] Although St. Paul cited liability risks as the reason for its withdrawal, it is also noteworthy that St. Paul lost a lot of money in the Enron scandal.[57] In addition, St. Paul engaged in a premium price war in the 1990s, using the go-go stock market to cover the spread and invested reserves grew so large that some of the funds were released to the bottom line as profit. When the stock market crashed, however, St. Paul was left with the option of exiting the market or increasing premiums.[58]

Both the American Medical Association and members of the insurance industry acknowledge the role the insurance industry has played in creating the latest medical malpractice crisis. In an internal memo from the AMA's Board of Trustees, the author states that "the insurance underwriting cycle is now at a point where insurers have both pricing power and a need to increase revenues through premiums as returns on investments are no longer able to subsidize underwriting losses and as insurers have suffered large claim losses in other areas."[59] The author also stated the following:

> For several years, insurers kept prices artificially low while competing for market share and new revenue to invest in a booming stock market. As the bull market

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[53] Cummings *et al.*, eds. Cycles and Crises in Property/Casualty Insurance: Causes and Implications, NAIC, 1991 at 339; *see also Risk Managers Blame Insurers for Renewal Woes*, National Underwriter, Jan. 14, 2002.

[54] *See Risk Managers Blame Insurers for Renewal Woes*, National Underwriter, Jan. 14, 2002.

[55] *See Year in Review*, Business Insurance, Dec. 24, 2001 ("To be sure, the market began firming in 2000. But the Sept. 11 terrorist attacks sent insurance prices skyrocketing far beyond the estimates of increases that earlier were being attributed to a normal hard cycle.").

[56] *See* The St. Paul Companies 2001 Annual Report at 3.

[57] Doroshow statement.

[58] Todd Sloane, *Back on the tort reform merry-go-round*, 32 Modern Healthcare 28, July 15, 2002.

[59] Report 35 of the Board of Trustees (A-02) on Liability Reform, at p.2.

> surged, investments by these historically conservative insurers rose to 10.6% in 1999, up from a more typical 3% in 1992. With the market now in a slump, the insurers can no longer use investment gains to subsidize low rates. The industry reported realized capital gains of $381 million last year, down 30% from the high point in 1998, according to the A.M. Best Company, one of the most comprehensive sources of insurance industry data.[60]

Similarly, a bi-partisan committee of the West Virginia legislature stated that the "insurance industry has played a role in the continuing limitations on accessible and affordable insurance coverage for the health care providers" and that "any limitations placed on the judicial system will have no immediate effect on the cost of liability insurance for health care providers."[61] The National Conference of State Legislatures has stated that falling interest rates for bonds and stock prices weakened insurers' main source of profit– their investment income.[62] The Physician Insurers Association of America confirmed that investment income contributed 47% to its companies' revenue in 1995, but only 31% in 2001.[63]

Still, despite this history and the insurance industry and AMA's own admissions, H.R. 5 addresses none of these problems. It does nothing about the insurance companies' bad investment practices or the insurance companies' boom and bust cycles. It does nothing to repeal the anomalous McCarran-Ferguson antitrust exemption for the insurance industry.[64] It does nothing to require that medical malpractice premium increases be justified or to even permit health care providers to challenge these increases, despite the fact that many state laws are deficient in these areas.[65] Rather, as in every other cyclical insurance industry "crisis," the target and focus have been the legal system and restrictions on victims' rights to recovery.

### C. Empirical evidence establishes that liability limitation laws have not had a

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[60] *Id*.

[61] *Final Report of the Insurance Availability and Medical Malpractice Industry Committee*, Jan. 7, 2003.

[62] *See* Eisler *et al*., *supra* note 32.

[63] *Id*.

[64] *See supra* note 50.

[65] Only a handful of states, including Alabama, Arizona, Illinois, New York and Oklahoma require that rates be filed and approved by the state insurance department before they can be used. *See* National Association of Insurance Commissioners, Compendium of State Laws on Insurance Topics, Rate Filing Methods For Property/Casualty Insurance, Workers' Compensation, Title, 2002.

**significant impact in reducing insurance premiums.**

Supporters of H.R. 5 argue that jury awards have skyrocketed, which in turn has caused malpractice premiums to increase, doctors to practice defensive medicine, and doctors to leave their practices in certain states with high premiums. They argue that federal restrictions on victims' abilities to pursue and collect on malpractice claims will reduce these problems. A review of the empirical data indicates that the proponents' arguments are incorrect and legal restrictions like those contained in H.R. 5 will not increase consumer welfare.

First, the empirical data shows that settlements and jury awards, including punitive damages, are not increasing at a rate far beyond the rate of inflation. According to the actuarial analysis of medical malpractice insurance conducted by J. Robert Hunter, Director of Insurance for the Consumer Federation of America,[66] the average malpractice payout has not changed much over the decade, and continues to hover at approximately $30,000 without any adjustment for inflation.[67] For the decade ending in December 2000, each closed claim for medical malpractice, including million dollar verdicts, averaged only $27,824.[68]

With regard to actual jury awards, data from the National Practitioner Data Bank shows that the average judgment declined in the first nine months of 2002, dropping from $426,247 from $593,647 in 2001.[69] This startling statistic, the most recent empirical evidence on jury awards, cuts right to the heart of the rationale for the bill.

Supporters of H.R. 5 cite anecdotal evidence that jury awards are increasing. One such study, conducted by Jury Verdict Research ("JVR") and released in March 2002, showed that jury awards in medical malpractice cases jumped 43% from 1999 to 2000.[70] Studies such as this,

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[66] *See* Letter from J. Robert Hunter, Director of Insurance for the Consumer Federation of America, to Joanne Doroshow, Executive Director of the Center for Justice & Democracy (Oct. 13, 2001) and attached spreadsheet [hereinafter "Hunter analysis"]. To conduct this analysis, Mr. Hunter used the most recent insurance data available from the National Association of Insurance Commissioners and A.M. Best and Company. *Id*.

[67] *Id*; *see also Medical Malpractice Insurance: Stable Losses/Unstable Rates*, Americans for Insurance Reform, Oct. 10, 2002 ("Not only has there been no 'explosion' in medical malpractice payouts at any time during the last 30 years . . . payments (in constant dollars) have been extremely stable and virtually flat since the mid-1980s.").

[68] *Id*.

[69] National Practitioner Data Bank.

[70] Jennifer E. Shannon and David Boxold, Medical Malpractice: Verdicts, Settlements and Statistical Analysis, Jury Verdict Research, 2002.

however, are too narrowly focused to provide the complete picture. The JVR study cites data that is skewed toward the high-end and doesn't include defense verdicts (verdicts in which no money was awarded), verdicts in non-jury trials, verdict reductions by remittitur, or verdicts overturned on appeal.[71] The JVR and similar studies are not adjusted for inflation and have no relation to what insurance companies actually pay out to claimants.[72]

Punitive damages, which are designed to deter willful and wanton misconduct, are infrequently awarded. According to Department of Justice statistics, in 1996 only 1.1% of medical malpractice plaintiffs who prevailed at trial were awarded punitive damages and juries awarded only 1.2% of those awards.[73]

Second, medical malpractice premiums have not increased beyond the rate of inflation. The evidence compiled by Mr. Hunter shows that inflation-adjusted medical malpractice premiums have actually declined in the last decade.[74] Average premiums per doctor climbed from $7,701 in 1991 to $7,843 in 2000, an increase of only 1.9%. When adjusted for inflation, these figures demonstrate premiums have actually decreased by 32.5%.[75] A recent USA Today study found that doctors spend less on malpractice insurance –3.2% of their revenue–than on rent.[76] Equally important, Mr. Hunter's analysis supports the conclusion that the cost of medical malpractice at the national health care expenditure level is quite low: for every $100 of national heath care costs, medical malpractice insurance costs 66 cents, and in 2000 the cost was 56 cents,

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[71] JVR admitted that its 2,951-case malpractice database has large gaps in it–it collects award information sporadically and unsystematically, does not know how many it misses, cannot calculate the percentage change in the median for childbirth negligence cases, and excludes trial victories by doctors and hospitals that are worth zero dollars. Press Release, Flawed Jury Data Masks Trends, Center for Justice and Democracy (Mar. 23, 2002); *see also* Todd Sloane, *Back On The Tort Reform Merry-Go-Round*, 32 Modern Healthcare 28, July 15, 2002; Rachel Zimmerman and Christopher Oster, *Assigning Liability: Insurers' Missteps Helped Provoke Malpractice 'Crisis'–Lawsuits Alone Didn't Cause Premiums to Skyrocket; Earlier Price War a Factor–Delivering Ms. Kline's Baby*, The Wall Street Journal, A1, June 24, 2002 (discussing JVR's incomplete study).

[72] *Id*.

[73] Tort Trials and Verdicts in Large Counties, 1996, U.S. Department of Justice, Bureau of Justice Statistics, NCJ 179769 (August 2000), p. 7.

[74] Hunter Analysis, *supra* note 66.

[75] *Id*.

[76] *See* Eisler *et al*., *supra* note 32.

the second lowest rate of the decade.[77]

Third, there is little evidence to support proponents' claim that doctors, fearing litigation, engage in the practice of defensive medicine. Less than 8% of all diagnostic procedures are performed because of liability fears, and most doctors who use aggressive diagnostic procedures do so because they believe the tests are medically indicated.[78] A study conducted by the non-partisan Office of Technology Assessment ("OTA") found that "in the majority of clinical scenarios used in OTA's and other surveys, respondents did not report substantial levels of defensive medicine, even though the scenarios were specifically designed to elicit a defensive response."[79] The OTA further found that "[c]onventional tort reforms that tinker with the existing process for resolving malpractice claims while retaining the personal liability of the physician are [unlikely to] alter physician behavior."[80] The effects of H.R. 5's limitations on defensive medicine are therefore likely to be small.

Fourth, studies show that, despite claims by doctors' groups and the insurance industry,[81] doctors are not leaving certain fields because they cannot afford the insurance premiums. Data from the American Medical Association actually shows that there are 4.4% more physicians in-patient care per 100,000 of the population in states without damage caps.[82] There are 5.8% more ob/gyn physicians per 100,000 women in states without caps.[83] And in states without malpractice limitations, there are 233 physicians per 100,000 residents, while in states with malpractice limitations, there are 223 physicians per 100,000 residents.[84]

Studies conducted in particular states make this clear. For example, Charleston Gazette

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[77] Hunter Analysis, *supra* note 66.

[78] OTA Report on Legal Reforms, *supra* note 46 at 74.

[79] *Id*.

[80] *Id*. at 92.

[81] See Statement of the American Medical Association to the House Committee on Energy and Commerce, 107th Cong. at 2-7 (July 17, 2002); Statement of the National Medical Liability Reform Coalition, before the House Committee on Energy and Commerce, July 17, 2002, 107th Cong., at 2 (July 17, 2002).

[82] American Medical Association, Physician Characteristics and Distribution in the U.S. (2001 ed.).

[83] Health Care State Rankings (Morgan Quitno Press, 2001).

[84] Senate Congressional Record, July 30, 2002, S7534.

reporters Lawrence Messina and Martha Leonard's series "The Price of Practice"[85] found that, contrary to claims by the West Virginia Medical Association that doctors had left the state because of its lack of liability limitation laws, the number of doctors in West Virginia had actually increased. In fact, between 1990 and 2000 the number of doctors had increased by 14.3%, a rate twenty times greater than the population.[86]

The same is true in Pennsylvania. A census conducted by the Pennsylvania Medical Professional Liability Catastrophe Loss Fund found that between 1990 and 2000, the number of doctors increased by 13.5%, while the population increased by only 3.4%.[87] Not only is Pennsylvania not losing doctors, it had more doctors in 2001 than it did in the preceding five to ten years.[88] Furthermore, the Philadelphia Inquirer notes that in 2000, "Pennsylvania ranked ninth-highest nationally for physician concentration, a top-10 position it has held since 1992. There were 318 doctors for every 100,000 residents in 2000, according to the American Medical Association."[89]

Fifth, there is no evidence to support the claim that restrictions on malpractice litigation will bring about appreciable health care savings. One reason is that medical negligence recoveries in this country in 2001 added up to $4.5 billion. Amidst a health care system that has about $1.4 trillion worth or transactions, recoveries for malpractice constitute less than 1 percent of the cost of healthcare.[90]

Moreover, there is scant quantitative evidence that previous state attempts have

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[85] Martha Leonard, *State Has Seen Sharp Increase in Number of Doctors*, Sunday Gazette Mail, Feb. 25, 2001.

[86] *Id*.

[87] Ann Wlazelek, *Doctors' Ad Campaign Baseless; They're Not Fleeing Pa., but Malpractice Straits Create 'Hostile' Climate*, Morning Call, Mar. 24, 2002; Josh Goldstein, *Recent Census of Doctors Shows No Flight from Pa.*, Philadelphia Inquirer, Oct. 2, 2001.

[88] Goldstein, *supra* note 87.

[89] Wlazelek, *supra* note 87. Studies done on the ob/gyn market in New York yield similar conclusions. *See* New York Public Interest Research Group Study (available at: http://www.nypirg.org/ health/malpractice_facts.html (last visited Feb. 1, 2003) (N.Y. ranked 3rd in the nation in number of ob/gyn's per capita; the number of physicians in N.Y. has skyrocketed and increasing at a rate faster than the national average; N.Y. ranked 2nd in number of doctors per capita).

[90] *See* Lorraine Woellert, *Commentary: A Second Opinion on the Malpractice Plague*, Business Week, Mar. 3, 2003.

accomplished this purported goal.[91] In a comparison of states that enacted severe tort restrictions during the mid-1980's and those that resisted enacting any liability limitation laws, no correlation was found between such laws and insurance rates.[92] Indeed, some of the resisting states experienced low increases in insurance rates or loss-costs relative to the national trends, while some states that enacted liability limitation laws experienced high rate or loss cost increases relative to the national trends. For example, in 2002, Michigan, a state with caps, had one of the highest average premiums in the country. Minnesota and Oklahoma, two states without caps, had two of the three lowest average rates in the country.[93] Furthermore, data provided by Medical Liability Monitor in 2001 showed that in the practice of internal medicine, states with caps on damages had higher premiums than states without caps.[94] For general surgeons, insurance premiums were 2.3% higher in states with caps on damages.[95] And for ob/gyn's, premiums were only 3.3% lower in states with caps on damages.[96] On average, malpractice premiums were no higher in the twenty-seven states that have no limitations on malpractice damages, than in the twenty-three states that have such limits.[97]

The vast majority of the evidence shows that liability limitation laws do little if anything to reduce medical malpractice premiums.[98] For example, a New Jersey Medical Society estimated

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[91] It is hardly a foregone conclusion that such restrictions will "fix" the problem. In fact, both Republican and Democratic members of the Judiciary Committee requested the General Accounting Office to conduct an inquiry into the effect of state tort laws on medical professional liability premium increases nationwide.

[92] *See Premium Deceit, supra* note 2.

[93] *See 2002 Medical Liability Monitor, supra* note 3.

[94] *See 2001 Medical Liability Monitor, supra* note 4.

[95] *Id*.

[96] *Id*.

[97] *See* Senate Congressional Record, *supra* note 6. Moreover, studies show that rising insurance rates have been a trend in the entire commercial industry, not just in the medical malpractice industry. Insurance prices have risen by 21% for small commercial accounts, by 32% for mid-size commercial accounts, and by 36% for large commercial accounts. Insurance for the construction industry, the commercial automobile industry, the property industry, the workers' compensation industry, and others have all increased between 24% and 56%. *See* Council of Insurance Agents and Brokers, 4th Quarter 2001 Survey, released January 2002.

[98] Insurance industry spokespersons practically admit this. As Sherman Joyce, President of the American Tort Reform Association (ATRA), stated, "We wouldn't tell you or anyone that the reason to pass tort reform would be to reduce insurance rates." *Study Finds No*

that a state cap of $250,000 for non-economic damages might result in 5% to 7% savings for physicians.[99]

The California experience is perhaps the best example of this trend. In 1975, California enacted into law the "Medical Injury Compensation Reform Act" ("MICRA"), after which many provisions of H.R. 5 are modeled, including caps on non-economic damages, collateral source offsets, and limitations on attorneys' fees.[100] Despite these "reforms," premiums for medical malpractice insurance in California grew more quickly between 1991 and 2000 than the national average (3.5% vs. 1.9%, respectively).[101] Between 1975 and 1993, California's health care costs rose 343%, almost double the rate of inflation.[102]

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*Link Between Tort Reforms and Insurance Rates*, Liability Week, July 19, 1999. ATRA's General Counsel, Victor Schwartz, told *Business Insurance* that "many tort reform advocates do not contend that restricting litigation will lower insurance rates, and 'I've never said that in 30 years.'" Michael Prince, *Tort Reforms Don't Cut Liability Rates, Study Says*, Business Insurance, July 19, 1999. Debra Ballen, the executive vice president of the American Insurance Association, stated that "insurers never promised that tort reform would achieve specific PREMIUM savings." Press Release, *AIA Cites Fatal Flaws in Critic's Reports on Tort Reform*, Mar. 13, 2002. And Florida insurers, writing about Florida's omnibus tort reform law of 1986 said that the "conclusion of the study is that the noneconomic cap . . . will produce little or no savings to the tort system as it pertains to medical malpractice." *Medical Professional Liability, State of Florida*, St. Paul fire and Marine Insurance Company, St. Paul Mercury Insurance Company.

Moreover, studies conducted by the National Association of Attorneys General and state commissions in New Mexico, Michigan and Pennsylvania confirmed that the crisis was caused not by the legal system but rather by the insurance cycle and mismanaged underwriting by the insurance industry. Francis X. Bellotti, Attorney General of Massachusetts, et al., Analysis of the Causes of the Current Crisis of Unavailability and Unaffordability of Liability Insurance (Boston, MA: Ad Hoc Insurance Committee of the National Association of Attorneys General, May 1986).

[99] *See* Eisler *et al., supra* note 32. One study suggested that payouts may be rising not because of noneconomic damage awards but because of "higher awards for what are called economic damages – the patient's medical bills, lost wages and other expenses." *Id*.

[100] *See* Cal. Civ. Proc. Code § 667.7 (West 1987) (providing for periodic payment of damages); *id*. § 1295 (West 1982) (allowing physicians and patients to contract for binding arbitration); Cal. Civ. Code § 3333.1 (West 1997) (allowing collateral source evidence); id. § 3333.2 (providing limitation on noneconomic damages); Cal. Bus. & Prof. Code § 6146(a) (West 1990) (limiting contingency fees).

[101] Hunter analysis, *supra* note 66.

[102] Data provided by Consumers' Union.

A comprehensive study of MICRA's impact conducted in 1995 found the following: (1) per capita health care expenditures in California have exceeded the national average every year between 1975 and 1993 by an average of 9% per year; (2) California's medical malpractice liability premiums actually increased by 190% in the twelve years following enactment of MICRA; (3) hospital patient costs are higher in California than in other major states; and (4) California's health care costs have continued to increase at a rate faster than inflation since the passage of MICRA.[103]

Some of MICRA's supporters claim that MICRA caused California's insurance premiums to drop. To the extent that is true, the reduction has nothing to do with MICRA and more to do with Proposition 103, which passed the California legislature in 1988. Among other things, Proposition 103 prohibited annual increases greater than 15% by insurers without public hearing, and required insurers to rebate earlier premiums and led to a freeze on premiums for several years.[104] As a result of Proposition 103, insurance companies refunded over $1.2 million to policyholders, including doctors.[105] Within three years of passage of Proposition 103, total medical malpractice premiums had dropped by 20.2% from the 1998 high.[106]

Not only does the evidence show that California's attempt failed to lower premiums for doctors, it also shows that California's insurance companies are reaping excessive profits in the aftermath of MICRA. In 1997, California's insurers earned more than $763 million, yet paid out less than $300 million to claimants.[107] The National Association of Insurance Commissioners reported the following: (1) malpractice insurance profits are ten times greater than the profits of other lines of insurance in California; (2) the average profit for malpractice insurance in California was 25.40% of the collected premium; and (3) less than half of medical malpractice premiums are paid to claimants–only 38.4% of medical malpractice premiums collected in California since 1988.[108]

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[103] *See* Proposition 103 Enforcement Project, MICRA: The Impact on Health Care Costs of California's Experiment With Restrictions on Medical Malpractice Lawsuits, 1995.

[104] *See* Testimony of Harvey Rosenfield, before the House Committee on Energy and Commerce, Feb. 10, 2003; *see also* Joseph B. Treaster, *Malpractice Insurance: No Clear or Easy Answers*, N.Y. Times, Mar. 5, 2003.

[105] *Id*.

[106] *Id*.

[107] California Department of Insurance.

[108] National Association of Insurance Commissioners, Profitability By Line By State in 1997 (Dec. 1998).

## III. H.R. 5 Goes Beyond Medical Malpractice And Applies To Insulate HMO's Insurers, Drug Companies, And Manufacturers And Distributors Of Medical Devices.

Although H.R. 5's proponents frequently tout it as a medical malpractice bill, its scope is far broader. In fact, the bill applies to (1) lawsuits against HMOs and other insurers, and (2) products liability claims against drug companies and manufacturers and distributors of medical devices.[109]

### A. H.R. 5 completely preempts states' patients' bills of rights that have allowed HMOs to be sued for wrongful actions.

As currently drafted, this bill guts HMO reform laws the states have already passed. We find it extremely problematic that legislation purporting to be a medical malpractice bill would be broad enough to cover lawsuits against HMO's and other insurers, particularly because such legislation preempts patients' bills of rights passed by some states. For example, Arizona's patients' bill of rights has no limits on damages for HMO lawsuits.[110] California, on which much of H.R. 5 is based, also has no HMO caps.[111] Georgia's statute has no caps for non-economic damages in lawsuits against HMOs.[112] Nor does Maine's HMO statute.[113] Finally, Oklahoma and Washington have no limitations on non-economic damages.[114] H.R. 5 completely eviscerates the protections specifically enacted by these states.

### B. H.R. 5 also covers products liability lawsuits against manufacturers and distributors of medical devices and drugs.

H.R. 5 exempts from liability for punitive damages manufacturers and distributors of medical devices, as well as pharmaceutical companies, who have obtained FDA approval.[115] If the FDA mistakenly allows a defective product on the market, the victims would not be able to sue at all. And, even if the FDA does not approve the device, manufacturers and distributors would still be shielded from punitive damage liability if the product is "generally recognized among qualified

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109 H.R. 5, § 9(7); *see supra* note 23.

110 Az. Rev. Stat. § 20-3153 *et seq*. (2000).

111 Ca. Civil Code § 3428 (West 1999).

112 Ga. Code Ann. § 51-1-48 *et seq*. (1999).

113 Me. Rev. Stat. Ann. Tit. 24, § 4313 (West 1999).

114 Okla. Stat. Tit. 36, § 6593 *et seq*. (2000); Wash. Rev. Code § 48.43.545 (2000).

115 H.R. 5, § 7(c).

experts as safe and effective" pursuant to FDA regulations.[116]

Moreover, these federal regulators approve the design of the product before it enters the manufacturing process only; they do not approve the manufacturing of each batch of a product. Nevertheless, the manufacturer of a defective product is exempt from punitive damages under this bill. Examples of products such as the Dalkon Shield, the Cooper-7 IUD device, high absorbency tampons linked to toxic shock syndrome, and silicone gel breast implants provide further reasons for our concerns. Each of these deadly products was approved by the FDA.[117]

## IV. H.R. 5 Raises Constitutional And Federalism Concerns

### A. Constitutional Concerns

Among the many problems with H.R. 5, we are also concerned that the bill may be unconstitutional under the Commerce Clause, the Fifth Amendment, and the Seventh Amendment.

First, the bill as drafted invites legal challenges to Congressional authority to legislate in this area, given the Supreme Court's recent Commerce Clause jurisprudence. There is a genuine issue as to whether H.R. 5 is a permissible exercise of Congress' power to regulate interstate commerce,[118] especially when applied to purely intrastate medical services. The bill contains no interstate commerce jurisdictional requirement, and merely makes a flat and unsubstantiated assertion that all of the activities it regulates affect interstate commerce.[119] The Supreme Court

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[116] H.R. 5, § 7(c)(1)(B); *see supra* note 17.

[117] The bill does provide exceptions where manufacturers or distributors knowingly misrepresented to or withheld from the FDA information that it was required to submit, and where a person made an illegal payment to an official at the FDA. This provision alleviates only one of many concerns we have about H.R. 5's extreme limitation on the availability of punitive damages.

[118] Article I, Section 8 of the Constitution provides, *inter alia,* "Congress shall have Power ... to regulate Commerce with foreign Nations and among the several States ... ." U.S. Const. art I, § 8, cl. 3.

[119] Section 2 of the bill states that "Congress find that the health care and insurance industries are industries affecting interstate commerce and the health care liability and litigation systems existing throughout the United States are activities that affect interstate commerce by contributing to the high cost of health care and premiums for health care liability insurance purchased by health care system providers." According to the *Lopez* Court, one of the problems with the school gun ban was that it contained "no express jurisdictional element which might limit its reach to a discrete set of firearms possessions that additionally have an explicit connection with

repeatedly has frowned upon federal intervention into areas like medical malpractice law that have been traditionally reserved to the states.[120]

The bill also invites challenges that it violates the Fifth Amendment, which provides that no person shall be "deprived of life, liberty, or property without due process of law,"[121] a proscription which has been held to include an equal protection component.[122] Plaintiffs will no doubt argue that the law does not provide a legislative *quid pro quo* and, as such, violates the Fifth Amendment. In exchange for depriving plaintiffs of their common law rights, the bill does not provide any offsetting legal benefits, at least to the parties directly harmed by the loss of their common law rights.

Finally, the bill may violate the Seventh Amendment, which provides, "[i]n suits at common law, where the value in controversy shall exceed twenty dollars, the right of trial by jury shall be preserved, and no fact tried by a jury shall be otherwise re-examined in any Court of the United States, than according to the rules of the common law."[123] Because the bill eliminates the right of a jury to determine the appropriate amount of punitive and non-economic damages, H.R. 5 arguably deprives a plaintiff of the right to jury trial with respect to those elements of the case. These problems are highlighted by the fact that courts in some states that have enacted similar liability limitation laws, such as caps on non-economic damages and collateral source offsets, have ruled such reforms unconstitutional as violative of equal protection, due process, and the right to a trial by jury and access to courts.[124]

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or effect on interstate commerce."

[120] The Court in *Lopez* observed that there were certain traditional areas of state law, such as criminal law and education, which should be off limits to federal intervention. The concurrence by Justices Kennedy and O'Connor also reasoned that the federal government should avoid involving itself in areas which fall within the "traditional concern of the states," noting that over 40 States had adopted laws outlawing the possession of firearms on or near school grounds.

[121] U.S. Const. amend. V.

[122] *See Bolling v. Sharpe*, 347 U.S. 497 (1954) (Fifth Amendment due process found to incorporate equal protection guarantees in case involving public school desegregation by the Federal Government in the District of Columbia).

[123] U.S. Const. amend. VII.

[124] Specifically, thirty-one states (AL, AZ, CA, CO, FL, GA, ID, IL, IN, KS, KY, LA, MO, NE, NH, NM, NC, ND, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, WA, WI, WY) have ruled that such sweeping restrictions on the rights of medical malpractice victims are unconstitutional. Courts in twenty states (AL, CO, FL, GA, ID, IL, KS, NE, NH, ND, OH, PA,

### B. Federalism Concerns

We are also concerned that the bill imposes the will of Congress on what has traditionally been exclusively a state law issue. As such, H.R. 5 could undermine over two centuries of respect for federalism by superimposing a new set of federal standards on the States.

Federalizing medical malpractice lawsuits will not result in uniformity. However well articulated, H.R. 5 will be applied in many different contexts and will be interpreted and implemented differently by both state and federal courts.[125]

Moreover, H.R. 5 takes away the state Supreme Courts' role as the final arbiters of their tort laws. Yet, the Republican majority stated that this is precisely the goal H.R. 5 is trying to accomplish. At the markup of H.R. 5, several members discussed the crisis in Florida and the fact that the Florida legislature has been unsuccessful in capping damages for medical malpractice cases. Mr. Wexler asked: "So what is it that we in this Congress are doing that is preventing the Florida legislature from adopting whatever tort reform it sees fit to do?"[126] Rep. Feeney (R-Fla.) responded as follows:

> Actually, Congress isn't doing anything to prevent the Republican or formerly Democratic legislature from doing the sorts of things that we need to do here. It is the six Democrats on the Florida Supreme Court. I would refer the

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OK, OR, SC, SC, TX, UT, WA, WI) have ruled caps or limitations on medical malpractice damages to be unconstitutional. Courts in NH and PA have ruled that statutory limitations on attorneys fees in medical malpractice cases are unconstitutional, unfairly burdening medical malpractice victims and their lawyer, or resulting in an unconstitutional infringement on the right to jury trial. Courts in KS, NH, ND, OH, PA, and RI have ruled that medical malpractice statutes eliminating the common law "collateral source" rule are unconstitutional violations of due process and equal protection. Eighteen states (AZ, CA, CO, GA, IN, KY, LA, MO, NH, NM, NC, OH, OK, SD, TX, UT, WA, and WI) have held that their states' medical malpractice ultimate statutes of limitations are unconstitutional. Courts in four states (AZ, KS, NH, and OH) have ruled that structured settlement provisions of their states' medical malpractice statutes are unconstitutional violations of the right to jury trial, equal protection and due process. And courts in eighteen states (AZ, CA, CO, GA, IN, KY, LA, MO, NH, NM, NC, OH, OK, SD, TX, UT, WA, and WI) have ruled similar restrictions unconstitutional for failing to include adequate discovery provisions, for imposing restrictions which are too short in time, and for discriminating against minors or incompetent adults, in violation of equal protection, open courts, or due process guarantees, or the privileges and immunities clauses of state constitutions.

[125] 1995 Product Liability Hearings, Statement of the Conference of Chief Justices at 6-7.

[126] Markup of H.R. 5, Transcript at 45.

> gentleman to Smith v. the Department of Insurance, April 23, 1987, when the Supreme Court basically said that under [Florida's] right of access provisions, under the Florida Constitution, that a $450,000 cap would be unconstitutional.
>
> So the point of the matter is that judges with certain partisan attitudes actually have prevented the people's legislature from enacting the very thing that we are trying to do here, and that is to preserve access to our doctors for the patients that I represent throughout the district.[127]

The argument Mr. Feeney makes is very problematic. Whatever reason he attributes to the Florida Supreme Court's decision to strike down the legislation imposing caps on damages in medical malpractice cases, the fact remains that the Florida Supreme Court should be the final arbiter of that issue. It violates principles of federalism for the United States Congress to decide that, because it does not like a decision made by the Florida Supreme Court, it should enact legislation that would overturn the court's decision.

H.R. 5 reaches far into state substantive civil law, forcing states to provide the necessary judicial structure to resolve medical malpractice disputes without permitting them to decide the social and economic questions in the law that their courts administer.

## V. Specific Concerns

In addition to the general problems raised above concerning the overall purpose and effect of H.R. 5, we have a number of specific concerns relating to particular provisions of the legislation. Most importantly, we are concerned that H.R. 5 does not solve the alleged insurance and litigation crises but rather unjustly restricts a patient's right to recover for injuries inflicted by a negligent and careless health care provider. The following is an itemization of some of the most pressing problems adopted by the majority in passing H.R. 5.

### A. $250,000 aggregate cap on non-economic damages[128]

We particularly object to the $250,000 cap on non-economic damages for three reasons: it is manifestly unfair, it discriminates against women and children and those in low-economic brackets, and it does not take into account inflation.

First, the cap is unfair because it puts a price tag on the most horrendous of injuries and

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[127] *Id*. at 46.

[128] Non-economic damages compensate victims for the human suffering they experience as the result of negligent conduct. Although intangible, these injuries are real and include infertility, permanent disability, disfigurement, pain and suffering, loss of a limb or other physical impairment. These damages are not accounted for in damages for lost wages, which are unrestricted under H.R. 5.

applies a "one-size-fits-all" philosophy that objectifies and erases the person and uniqueness of his or her suffering. An incident told by Kathy Olsen, who attended the victims' forum held by House Democrats on February 11, 2003,[129] illustrates the harsh reality of H.R. 5. Ms. Olsen told her son, Steve's, story. Steve Olsen is blind and brain damaged because of medical negligence. When he was two years old he fell on a stick in the woods. Steve's doctor gave Steve steroids and sent him home. Although his parents asked for a CAT scan, the doctor refused. The following day, Steve returned to the hospital in a coma because of the growing brain abscess he had developed, which would have been detected had the CAT scan been performed. At trial, the jury concluded that the doctor had committed medical malpractice and awarded $7.1 million in "non-economic" damages. One of the jurors explained that they saw Steve as a boy doomed to a life of darkness, loneliness and pain. He would never play sports, work or enjoy normal relationships with his peers. He would have to endure a lifetime of treatment, therapy, prosthesis fitting and around-the-clock supervision. The judge, however, was forced the reduce that damage award to $250,000 because of the state's cap.

Ms. Olsen is outraged by President Bush's statement that the jury system looks like a "giant lottery." Ms. Olsen declares: "California's malpractice law has failed innocent victims, consumers, and taxpayers. Under this law people are victimized twice, once by the wrongdoer and again by the laws that deny them the right to hold the wrongdoer accountable."[130] As to the cap on damages, Ms. Olsen says that the "law is regressive by hurting the most seriously injured victims, those who are permanently and catastrophically injured by medical negligence. . . . In California, and now proposed nationwide, no matter how old you are or how disabled you become or how catastrophic your injuries are, there is a one size fits all limit on your pain and suffering."[131]

Second, the $250,000 cap discriminates against women, children, seniors, and the poor.[132]

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[129] Democratic Forum on Malpractice, February 11, 2003, Transcript at 60.

[130] *Id*. at 62.

[131] *Id*.

[132] In their 1995 article, Thomas Koenig and Michael Rustad studied the effects of tort reforms on the different genders, finding that women are disproportionately affected by such reforms. Thomas Koenig and Michael Rustad, *His and Her Tort Reform: Gender Injustice in Disguise*, 70 Wash. L. Rev. 1 (1995). Specifically, the study found that women receive smaller economic verdicts for equivalent injuries because of lower overall wages. *Id*. at 78. And medical malpractice awards to women were almost three times more likely to include a pain and suffering component as those given to men. *Id*. at 84. This is true because women are most likely to suffer severe non-economic loss (loss of fertility, disfigurement, etc.) and be the victims of the types of medical malpractice that lead to punitive damages (sexual assault, fraud, false imprisonment, and extreme violation of medical standards, etc.).

These categories of victims do not have high economic damages and are more likely to receive a greater percentage of their compensation in the form of non-economic damages. The result is that homemakers and children will be limited to $250,000 in non-economic damages, but CEO's could recover millions of dollars.[133]

A striking example of how the one-size-fits-all cap harms victims without economic damages can be found in the case of Linda McDougal. Ms. McDougal went to the hospital for a biopsy after a routine mammogram disclosed a suspicious shadow on one breast. A few days later, her doctor called to tell her she had cancer and would need a double mastectomy. At the victims' forum, Ms. McDougal described the effect this news had on her: "My world was shattered."[134] After the operation, Ms. McDougal found out that she never had cancer–the pathologist mixed up Ms. McDougal's charts with another patient's. "The medical profession betrayed the trust I had in them. It's been very difficult for me to deal with this. My scars are not only physical, but emotional as well."[135] Ms. McDougal has not filed a lawsuit yet, but she knows that should Congress pass legislation capping non-economic damages, her recovery will be limited to $250,000 because she does not have economic damages. As Ms. McDougal said at the forum, she lost wages of about $8,000 and her hospital expenses were about $48,000, which her insurance company covered. But she went on: "My disfigurement from medical negligence is almost entirely noneconomic. . . . I could never have predicted or imagined in my worst nightmare that I would end up having both of my breasts removed needlessly because of a medical error. No one plans on being a victim of medical malpractice, but it happened."[136]

Another recent example is Jesica Santillan, a 17 year old girl from Mexico whose family moved to the United States so Jesica could receive a heart and lung transplant at Duke University Hospital.[137] The organs flown from Boston to Durham identified the donor's blood as Type-A blood, but the hospital mixed-up the paperwork and transplanted organs with Type-O-positive blood instead. As a result, Jesica, who had been waiting three years for the organs, suffered a near-fatal heart attack and a seizure. A machine kept her heart and lungs going for awhile, but on February 22, 2003, just two weeks after the initial surgery, Jesica died.[138] Like Linda McDougall,

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[133] *Id*.

[134] Democratic Forum on Malpractice, February 11, 2003, Transcript at 48.

[135] *Id*. at 49.

[136] *Id*. at 50-51.

[137] *See* AP, *Girl Near Death in Botched Transplant*, Wash. Post Feb. 19, 2003 at A02.

[138] *See* Shankar Vedantam, *Surgical Expertise, Undone by Error*, Wash. Post Feb. 24, 2003 at A01.

however, Jesica had no economic damages and, should her family decide to sue, would be capped at $250,000 under H.R. 5.

Third, the cap makes it hard for people with legitimate cases to find lawyers to represent them. As one attorney from California stated, "[e]ven in those cases resolved on the eve of trial, . . . [lawyers] typically have to invest up to $100,000 to hire experts and develop the cases. They would do the same work and invest the same amount of money to tackle a case with a potential payoff in the millions. So they choose the more lucrative cases."[139]

Finally, the $250,000 cap is based on MICRA's cap,[140] which was set in 1975 and has not been adjusted for inflation. A close look at California's numbers adjusted for inflation shows exactly what $250,000 is worth today. Using the consumer price index, the medical care value of $250,000 has dropped to just $38,877 over the 27 years since MICRA was enacted. One would need about $1,600,000 in 2002 for the equivalent medical purchasing power of $250,000 in 1975.

Representatives Nadler and Delahunt both offered amendments that would allow for adjustment of the $250,000 to the consumer price index.[141] As Mr. Nadler pointed out, "[T]he fact of the matter is what you are really saying is why don't we allow people zero recovery for pain and suffering; because if you index something at whatever number, take 50,000, 250,000, 550,000, and you don't index it, eventually that number is going to be almost zero. It is going to be almost worthless depending how long you want to go."[142]

### B. Abolition of joint and several liability

We oppose H.R. 5's total elimination of joint and several liability from medical malpractice

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[139] *See* Joseph B. Treaster, *Malpractice Insurance: No Clear or Easy Answers*, N.Y. Times, Mar. 5, 2003.

[140] Although based on MICRA, H.R. 5's cap on non-economic damages is much more restrictive. For example, California courts recognize a separate claim for loss of consortium–claims brought for loss to the marital relationship–brought by the spouse of an injured patient. The cap in H.R. 5 is a completely aggregate cap. Under H.R. 5, the amount of non-economic damages that can be recovered by an injured patient and his or her spouse cannot exceed $250,000 for non-economic losses.

[141] Mr. Nadler's amendment would have added the following language after $250,000 every time it appears in the bill: "(adjusted annually according to the adjustments in the consumer price index to the nearest thousand dollar)." Mr. Delahunt's amendment would have struck $250,000 each place it appears in the bill and replaced it with $1,600,000. Mr. Nadler's amendment was defeated by a vote of 17-16; Mr. Delahunt's amendment was defeated 15-14.

[142] Markup of H.R. 5, Transcript at p. 108.

cases because the result is to shift responsibility from the wrongdoer to the innocent victims of medical malpractice. Joint and several liability has been a part of the American common law for centuries.[143] The doctrine provides that all tortfeasors who are responsible for an injury are "jointly and severally" liable for the claimant's damages. This means the victim can sue all responsible defendants and recover from each one in proportion to that defendant's degree of fault, or sue any one defendant and recover the total amount of damages. A defendant who pays more than its share is then entitled, under the doctrine of contribution, to seek compensation from other responsible parties based on their degree of fault.[144] The doctrine is designed to help ensure that victims of wrongful conduct are able to fully recover damages for their injuries, especially when one or more of the defendants is judgment-proof.[145]

The majority's reasons for eliminating joint and several liability[146] in medical malpractice cases is nothing but an extreme reaction to mostly unsubstantiated anecdotal stories, rather than a moderate response to the facts. In the 2002 markup of H.R. 4600 Mr. Bachus gave a hypothetical of a drug dealer who gets shot during a drug deal gone bad, who then goes to the hospital and receives treatment from a doctor who is fatigued. Mr. Bachus raised the possibility that the drug dealer would be found to be 99 percent at fault and the hospital one percent at fault,

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[143] See e.g. Michael L. Rustad and Thomas H. Koenig, *Taming the Tort Monster: The American Civil Justice System As A Battleground of Social Theory*, 68 Brook L. Rev. 1 (Fall 2002); Matthew W. Light, *Who's the Boss?: Statutory Damage Caps, Courts, and State Constitutional Law*, 58 Wash. & Lee L. Rev. 315 (Winter, 2001).

[144] Restatement (Third) of Torts § 23 (1999).

[145] At the 2002 markup of H.R. 4600, Chairman Sensenbrenner stated the crux of the issue when, after acknowledging that the rule is "motivated by a desire to ensure that plaintiffs are made whole," he said: "The HEALTH Act, by providing a fair share rule, it apportions damages in proportion to a defendant's degree of fault and prevents unjust situations in which hospitals can be forced to pay for all damages for an injury, even when the hospital is minimally at fault." 2002 Medical Malpractice Hearing, Transcript at 16. As we see it, if one has to choose between protecting victims of malpractice or protecting hospitals who every so often may not receive contribution from the other wrongdoers, the choice is obvious. As Mr. Scott put it, "which is more fair? For the hospital to decide to apportion all of that amongst itself, which is all insured anyway? Or have the plaintiff have that possibility and lose 1 percent there because they couldn't find that one, or 2 percent there, and they collect all from this one and a little bit–this one goes bankrupt? Which is more fair? You've got somebody with a $100,00 judgment and 50 people, possibly, at fault." *Id*. at 31.

[146] The issue did not come up at the 2003 markup of H.R. 5, but was discussed at length in the 2002 markup of H.R. 4600.

but the drug dealer recovers 100 percent because of joint and several liability.[147] As Mr. Frank correctly pointed out, "a drug dealer who was shot and was 99 percent responsible and recovered . . . is the sort of example that makes no constructive contribution to the debate."[148]

These preposterous hypotheticals are the basis for the majority's extreme response–the elimination of the doctrine altogether–even though far more moderate responses previously have been propounded. For example, in 1999 the Congress passed the Y2K bill, which had several limitations on the total abolition of joint and several liability. First, it had a complete carve-out where the defendant acted with specific intent to injure the victim or knowingly committed fraud.[149] In addition, the Y2K Act provides that if portions of the victim's damage claim ultimately prove to be uncollectible, and the victim is an individual with a net worth of less than $200,000 and damages are greater than 10 percent of a victim's net worth, a solvent defendant is responsible for paying an additional 100 percent share of the liability, or an additional 150 percent of this amount if it acted with "reckless disregard for the likelihood that its acts would cause injury."[150]

### C. Limits on punitive damages in medical malpractice cases

The limitations on punitive damages are also of major concern to us for two reasons: the heightened standard is practically impossible for victims to prove,[151] and the $250,000 cap is inadequate in extreme cases of abuse, such as those involving rape or drugs.

First, the heightened standard for recovery–the requirement of clear and convincing evidence that the defendant acted with malicious intent to injure (or he was substantially certain the victim would suffer injury but failed to avoid such injury)–is so extreme it is practically criminal. This standard makes it almost impossible for victims who have been egregiously

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147 *Id*. at 28.

148 *Id*. at 34.

149 15 U.S.C. § 6605(c).

150 *Id*. § 6605(d).

151 H.R. 4600, § 7(a) ("Punitive damages may, if otherwise permitted by applicable State or Federal law, be awarded against any person in a health care lawsuit only if it is proven by *clear and convincing evidence* that such person acted with malicious intent to injure the claimant, or that such person deliberately failed to avoid unnecessary injury that such person knew the claimant was substantially certain to suffer." (emphasis added)).

wronged to recover punitive damages.[152]

Second, even victims who could meet this standard are still limited by the cap at $250,000 or two times the amount of economic damages. This cap completely eviscerates the deterrent effect punitive damages have on egregious misconduct of defendants because the threat of having to pay a maximum of $250,000 would not affect many large companies or wealthy individuals. Moreover, the cap applies no matter what the conduct, even in situations where a medical professional harmed a patient because he was under the influence of alcohol or drugs, or where a doctor sexually assaults his patient.[153]

### D. Elimination of punitive damages for products approved by the FDA.

In addition to the caps on punitive damages, we are especially troubled by the bill's abolition of punitive damages for products that have been approved by the FDA. Simply because a product has been approved by the FDA does not mean the company should be immunized from punitive liability when the product, despite such approval, causes severe harm to an individual. This is especially compelling given that studies have shown that medical devices cause approximately 53 deaths and over 1,000 serious injuries annually, costing approximately $26 billion annually.[154] Government safety standards, at their best, establish only a minimum level of

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[152] We also think this provision is unnecessary because punitive damages are so rarely awarded in medical malpractice cases. In fact, a Westlaw search of punitive damage award cases to date since 1980 shows that punitive damages were awarded in only twelve cases, most of which involved egregious conduct by the health care professional.

[153] In fact, a report by Public Citizen found that "47.7% of doctors [found to have been disciplined for sexual abuse or misconduct by a disciplinary board] were allowed to continue practicing, their behavior probably unknown to most if not all of their patients." Sidney Wolfe et al., *20,125 Questionable Doctors*, Public Citizen Health Research Group, Washington, D.C. (2000).

[154] A recent article by Robert Cohen and J. Scott Orr sets out startling statistics with respect to the medical implant industry. A few are as follows:

- During the past 10 years, 573 recall notices covering more than 2 million implants were issued for lapses such as mislabeling, structural failure, or manufacturing error. All but one of these errors were noticed by manufacturers, not the FDA.

- Of the 3500 proposed medical devices reviewed by the FDA last year, 98% were approved under an expedited process that requires no clinical testing.

- Federal law requires the FDA to inspect medical device manufacturers every two

protection for the public. At their worst, they can be outdated, under-protective, or under-enforced.[155]

Moreover, the bill completely insulates manufacturers and distributors of products and drugs from defects arising during the manufacturing process, which occurs after the FDA has given its approval of the device. This means that a drug company distributing an FDA-approved product, which is manufactured in a flawed manner that harms consumers would be insulated from punitive damages, even if the flawed manufacture was intentional or reckless.

And finally, banning punitive damages for FDA-approved products will have a disproportionate impact on women and seniors, who make up the largest class of victims of medical products. There are many examples of FDA-approved products that are dangerous and have caused harm to scores of women, including DES, the Dalkon Shield and Copper-7 IUDs, super-absorbent tampons, high-estrogen oral contraceptives, and the weight loss drug phen-fen.[156]

### E. Alteration of the collateral source rule and elimination of the doctrine of subrogation.

We dissent from the bill's alteration of the collateral source rule. The bill allows either party to introduce evidence to the jury of payment from a collateral source and eliminates the doctrine of subrogation.[157] The effect is to shift the costs of malpractice from negligent defendants to innocent victims.

The collateral source rule prevents a wrongdoer from reducing the amount of damages it

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> years, but due to budget constraints, it actually visits U.S. plants on average every five years and overseas plants ever 13 years.

*See* Robert Cohen and J. Scott Orr, *Faulty Medical Implants Enter Market Through Flawed System*, Newhouse News Service, 2002.

[155] The bill response to one of our concerns from last year's H.R. 4600 by providing an exception to the provision for cases where the manufacturer or distributor knowingly misrepresented to or withheld from the FDA information it was required to submit, and where a person paid an FDA official to secure market approval. H.R. 5, § 7(c)(4).

[156] *See also* Koenig and Rustad, *supra*, at 38-46 ("There are far too many examples of instances where the FDA could not by itself adequately protect the public from dangerous, defective medical devices") (citing Lack of Life Saving Medical Devices, Hearing on S. 687 Before the Subcomm. on Reg. and Gov't Info. Comm. of the Senate Comm. on Gov't Affairs, 103d Cong., 2d Sess. (testimony of Kristin Rand, counsel on behalf of Consumer's Union)).

[157] H.R. 5, § 6; *see supra* note 13.

must pay a victim by the amount the victim receives from outside sources.[158] Payments from outside sources often include health or disability insurance, for which the victim already paid premiums and taxes. The rule is fair because the doctrine of subrogation, which provides that the collateral source has the right to reimbursement from the victim out of the damage award, ensures that no source pays more than its share of the liability.[159]

We oppose this provision because it allows the jury to hear evidence of a payment a victim may have received from his or her insurance company–payment for which the victim contracted and paid premiums–and may reduce the amount of damages the victim can collect from the negligent defendant by that amount. In essence, the negligent defendant gets the benefit of the victim's health insurance contract.

In addition to shifting costs to the victim, eliminating the collateral source rule would discourage prudent insurance planning by penalizing consumers for acting responsibly[160] and would undermine the deterrent effect of the malpractice system by enabling negligent health care providers to avoid liability for damages they inflict.[161]

### F. Contingency fee limitations

In addition, we disagree with the provision in the bill limiting contingency fees for attorneys.[162] Contingency fee arrangements can serve a useful and essential function in the legal system.[163] They allow injured victims who could not otherwise afford legal representation access to the courts because the attorney agrees to take the case on behalf of an injured patient without

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158 *See, e.g.*, *Heflend v. Southern Cal. Rapid Transit Dist.*, 465 P.2d 61 (1970) for an analysis of the collateral source rule.

159 *See* Kenneth Abraham, Distributing Risk: Insurance, Legal Theory, and Public Policy, 1330-172 (1986); Fleming, *The Collateral Source Rule and Loss Allocation in Tort Law*, 54 Cal. L. Rev. 1478, 1481-85 (1966).

160 *See* James L. Branton, *The Collateral Source Rule*, 18 St. Mary's L.J. 883 (1987).

161 *See* Patricia M. Danzon, *The Frequency and Severity of Medical Malpractice Claims: New Evidence*, 49 Law & Contemp. Probs. 57, 72 (Spring 1986).

162 H.R. 5, § 5.

163 *See* Herbert M. Kritzer, *Lawyer Fees and Lawyer Behavior in Litigation: What does the Empirical Literature Really Say?*, 80 Tex. L. Rev. 1943 (2002); Herbert M. Kritzer, *Economic Policy Litigation Conference Seven Dogged Myths Concerning Contingency Fees*, 80 Wash. U. L.Q. 739 (Fall 2002).

obtaining any money up front from the client.[164] The attorney thus incurs a risk in taking on the case because if the client loses, the attorney never gets paid.[165] Not only does this help ensure that poor victims have access to the civil justice system, it also serves as a screening mechanism for unmeritorious cases on which attorneys will not take a risk.[166]

H.R. 5's restrictions make it more difficult for poor victims of medical malpractice with legitimate claims to find legal representation. Moreover, it is unfair to restrict victims' attorneys fees but not defendants, especially when defense attorneys are usually paid by the hour and thus have incentive to engage in meaningless litigation to drive up the costs.[167]

### G. Periodic payments

As with the other provisions of the bill, the provision regarding periodic payments harms victims and protects wrongdoers.[168] First, it allows the negligent party or insurance company to invest and earn interest on the victim's compensation. Second, it puts the onus on the victim, not the wrongdoer, to pursue the compensation in the event that the wrongdoer files for bankruptcy or refuses to pay. And if the wrongdoer files for bankruptcy, the chances of the victim ever receiving compensation for his or her loss is close to nothing. Finally, it leaves the victim without adequate resources in the event of an unanticipated medical emergency, if costs of the victims's medical care increase beyond his or her means, or a special medical technology is made available which the victim requires. In these circumstances, the injured patient would have to retain a lawyer to have the schedule modified.

### H. Reduced statute of limitations

Finally, we oppose this statute of limitations because it is a one year statute of limitations disguised as a three year statute of limitations. H.R. 5 provides that health care lawsuits must be commenced "3 years after the date of manifestation of injury or 1 year after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury, whichever occurs

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164 *Id*.

165 *Id*.

166 *Id*.

167 We also find it interesting that the majority would support a bill that is so anti-capitalistic. Restrictions on contingency fees are restrictions on compensation to attorneys who have worked hard and performed in the marketplace. This provision could not be more "anti-Republican."

168 H.R. 5, § 8; *see supra* note 22.

first."[169]

Although this provision addresses one of our concerns from last year–that the statute of limitations does not account for injuries that have long incubation periods, such as HIV–it still is extremely restrictive and harmful to patients. The three year provision essentially is a sham because the bill calls for the earlier of three years from the date of manifestation or one year from the date of discovery. Those two dates will almost always be the same–a patient will discover a disease on the same date the disease begins to manifest itself. As Mr. Delahunt stated, "such victims would only have 1 year, once they become aware of the condition, to file suit; hardly a reasonable opportunity to consider their legal options and to find a lawyer that is willing to take the case on."[170]

**Conclusion**

Collectively, the supposed "reforms" included in H.R. 5 would severely limit victims' ability to recover compensation for damages caused by medical negligence, defective products, and irresponsible insurance providers. In addition to raising core issues of fairness, the legislation would intrude into an area which has traditionally been the sole province of the states, many of which have enacted their own medical malpractice legislation in recent years. H.R. 5, which is designed to limit medical malpractice premiums and jury awards, presents a "fix" that is not supported by the empirical evidence; indeed it is being propounded at a time when the great wealth of data suggests that there is no medical malpractice "crisis" in our society. For these and other reasons set forth above, we strongly believe H.R. 5 should be rejected.

John Conyers, Jr.
Rick Boucher
Jerrold Nadler
Robert C. Scott
Melvin L. Watt
Sheila Jackson Lee
William D. Delahunt
Robert Wexler
Tammy Baldwin
Anthony D Weiner
Linda T. Sanchez

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[169] H.R. 5, § 3. The bill tolls the statute of limitations upon proof of fraud, intentional concealment, or the presence of a foreign body in the person injured. *Id*. In addition, there is an exception for minors who have sustained injury before the age of six. These victims may bring a lawsuit until the later of three years from the date of injury, or the date on which the minor attains the age of eight. *Id*.

[170] Markup of H.R. 5, Testimony of Mr. Delahunt, Mar. 5, 2003, Tr. at p.27.